

INVOICE

Care Provider / Facility Name

License No: [Number]
Street Address, City, State, Zip
Phone: (000) 000-0000

INVOICE #
[0000]
DATE
[MM/DD/YYYY]
BILLING PERIOD
[Start] - [End]

PATIENT / RESIDENT

[Full Name]
ID: [Patient ID]
Diagnosis Code: [ICD-10 Code]

BILL TO
[Responsible Party Name]
[Address]
[City, State, Zip]

Service Date	HCPCS/CPT Code	Description of Specialized Care	Units/Hrs	Rate	Amount
[Date]	[Code]	Memory Care - Residential Level [X]	[0]	\$0.00	\$0.00
[Date]	[Code]	Cognitive Therapy / Engagement Services	[0]	\$0.00	\$0.00

Service Date	HCPCS/CPT Code	Description of Specialized Care	Units/Hrs	Rate	Amount
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[Date]	[Code]	Medication Management & Monitoring	[0]	\$0.00	\$0.00
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[Date]	[Code]	Personal Care Assistance (ADLs)	[0]	\$0.00	\$0.00
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Subtotal: \$0.00

Adjustments/Insurance: (\$0.00)

Total Balance Due: \$0.00

Care Notes & Observations:

[Insert clinical summary or behavioral observations for the billing period here]

Payment Terms: Please make checks payable to [Facility Name]. Payment is due within 15 days of invoice date. Late fees may apply after [Date].